MEDICATION SHEET

Today's Date:

Pharmacy:

Drug Food Allergies/Reactions:

_____

_____

Please list your medications/herbs/vitamins below or indicate you have a list for the staff to photocopy, and give to the receptionist. ❑ Provided for the staff to photocopy.

Medication/Herbal/ Vitamin Name "Please Print"	***Dosage/ Strength***	***Route – How do you take?*** ***Example: By Mouth***	***Frequency – How often do you take?*** ***Example: Twice a day***	***Last time you took medication?***

Person completing the list: _____ **Date:** _____

#0020585 Gate 6/10
Chart Copy

MEDICATION SHEET

Brazosport Regional
FAMILY MEDICINE CENTER

Patient Name:_____ **DOB:** _____